

PetSmart, Inc.

Plan Document Number: G0031049

Group Policy Number: G0114822

Plan CC: Saskatchewan Part-Time Associates

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: September 1, 2010

Group Policy Effective Date: January 1, 2019

This Benefit Booklet has been specifically designed with your needs in mind, providing easy access to the information you need about the benefits to which you are entitled.

Group Benefits are important, not only for the financial assistance they provide, but for the security they provide for you and your family, especially in case of unforeseen needs.

Your employer can answer any questions you may have about your benefits, or how to submit a claim.

This booklet produced: December 20, 2023

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This Benefit Summary provides information about the specific benefits supplied by Manulife Financial that are part of your Group Plan.

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0114822.

Benefit Amount - 1 times your annual earnings, to a maximum of \$350,000 (minimum benefit amount of \$10,000)

Termination Age - your benefit amount reduces by 50% at age 65 and terminates upon your retirement.

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0114822.

Benefit Amount - increments of \$10,000, to a maximum of \$200,000

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

Dependent Life Insurance

The Dependent Life Insurance Benefit is insured under Manulife Financial's Policy G0114822.

Benefit Amount - \$10,000 spouse; \$5,000 each dependent child

Termination Age - employee's age 70 or retirement, whichever is earlier

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0114822.

Benefit Amount - 1 times your annual earnings, to a maximum of \$350,000 (minimum benefit amount of \$10,000)

Termination Age - your benefit amount reduces by 50% at age 65 and terminates at age 70 or retirement, whichever is earlier.

Extended Health Care

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Dispensing Fee Maximum - \$12.00 per prescription

Benefit Summary

Benefit Percentage (Co-insurance)

100% for

Hospital Care
Vision Care

90% for

Drugs

80% for

Professional Services
Medical Supplies and Services

Note:

The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.

The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.

The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - employee's retirement

ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

- drugs which by law or convention require a written prescription of a physician or dentist
- oral contraceptives, intrauterine devices and diaphragms
- injectable medications
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- non-prescription drugs and supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment)
- fertility drugs

Charges for the following expenses are not covered:

- the administration of serums, vaccines, or injectable drugs
- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence
- anti-smoking drugs
- anti-obesity drugs
- drugs used in the treatment of a sexual dysfunction

- Drug Maximums

Fertility drugs - \$10,000 per lifetime

Preventive vaccines and medicines (oral or injected) - \$1,000 per calendar year

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

Manulife Financial can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product, the maximum amount covered is the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

Reimbursement at the cost of a prescribed drug, where a lower cost alternative drug is available, will only be considered if medical evidence is provided by the treating physician to support why the lower cost alternative drug cannot be tolerated or is ineffective.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

- a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

Benefit Summary

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Vision Care

- eye exams, to a maximum of 1 exam per calendar year
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of \$250 per 12 months for persons under age 18 and \$250 per 24 months for persons age 18 and over
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be \$200 per 12 months for persons under age 18 and \$200 per 24 months for persons age 18 and over
- visual training, \$200 per lifetime per person

Professional Services

Services provided by the following licensed practitioners:

- **Chiropractor:** \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- **Osteopath:** \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- **Podiatrist/Chiropracist:** \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- **Massage Therapist:** \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- **Naturopath:** \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- **Speech Therapist:** \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- **Physiotherapist:** \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist

Benefit Summary

- Mental Health Practitioners*: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropractist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- Acupuncturist: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropractist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- Athletic Therapist: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropractist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist

*Mental Health Practitioners include Clinical Counsellors, Marriage and Family Therapists, Psychoanalysts, Psychologists, Psychotherapists and Social Workers only

Dental Care

The Benefit

Deductible - Nil

Dental Fee Guide - Current Fee Guide for General Practitioners for your province of residence

Benefit Percentage (Co-insurance)

90% for Basic Services - Level I

80% for Supplementary Basic Services - Level II

50% for Dentures - Level III

50% for Major Restorative Services - Level IV

50% for Orthodontics - Level V

Benefit Maximums

\$2,500 per calendar year combined for Level I, Level II, Level III and Level IV

\$2,000 per lifetime for Level V

Termination Age - employee's retirement

How to Use Your Benefit Booklet

Designed with Your Needs in Mind

The Benefit Booklet provides the information you need about your Group Benefits and has been specifically designed with YOUR needs in mind. It includes:

- a detailed Table of Contents, allowing quick access to the information you are searching for,
- Explanation of Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,
- a clear, concise explanation of your Group Benefits,
- information you need, and simple instructions, on how to submit a claim.

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of PetSmart, Inc. The information in this booklet is a summary of the provisions of the Group Policy for the Employee Life Insurance, Employee Optional Life Insurance, Dependent Life Insurance and Accidental Death and Dismemberment Benefits and the Plan Document for the Extended Health Care and Dental Care Benefits. In the event of a discrepancy between this booklet and the Policy or Plan Document (both available from your employer), the terms of the Policy or Plan Document will apply.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations.

Possession of this booklet alone does not mean that you or your dependents are covered. The Group Policy and Plan Document must be in effect and you must satisfy all the requirements of the Plan.

Where required by law, you or any claimant under the Group Policy and/or Plan Document has the right to request a copy of any or all of the following items:

- the Group Policy and/or Plan Document,
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the Group Policy and/or Plan Document.

Manulife Financial reserves the right to charge you for such documentation after your first request.

We suggest you read this Benefit Booklet carefully, then file it in a safe place with your other important documents.

How to Use Your Benefit Booklet

Your Group Benefit Card

Your Group Benefit Card is the most important document issued to you as part of your Group Benefit Program. It is the only document that identifies you as a Plan Member. The Group Policy Number, Plan Document Number and your personal Certificate Number may be required before you are admitted to a hospital, or before you receive dental or medical treatment.

The Group Policy Number, Plan Document Number and your Certificate Number are also necessary for ALL correspondence with Manulife Financial. Please note that you can print your Certificate Number on the front of this booklet for easy reference.

Your Group Benefit Card is an important document. Please be sure to carry it with you at all times.

Explanation of Commonly Used Terms

The following is an explanation of the terms used in this Benefit Booklet.

Adherence

use drug, service or supply in accordance with the terms for which it was prescribed.

Advisory Body

Manulife Financial approved external experts that may provide Manulife Financial with recommendations, applying a pharmacoeconomic or cost effectiveness evaluation.

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by your employer.

Birth

the complete live delivery of a child from its mother.

Covered Expenses

expenses that will be considered in the calculation of payment due under your Extended Health Care or Dental Care benefit.

Deductible

the amount of Covered Expenses that must be incurred and paid by you or your dependents before benefits are payable by your employer.

Dependent

your Spouse or Child who is covered under the Provincial Plan.

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months.

- Child

- your natural or adopted child, or stepchild, who is:
 - unmarried
 - under age 21, or under age 25 if a full-time student
 - not employed on a full-time basis, and
 - not eligible for coverage as an employee under this or any other Group Benefit Program
- a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependent. However, the child must have been covered under this Benefit Program immediately prior to that date.

A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on the employee for support, maintenance and care, due to a mental or physical handicap.

Explanation of Commonly Used Terms

Your employer may require written proof of the child's condition as often as may reasonably be necessary.

- a stepchild must be living with you to be eligible
- a newborn child shall become eligible from the moment of birth for Extended Health Care and Dental benefits and from 14 days old for Dependent Life

Disease Management Programs

an approach to healthcare that teaches patients how to manage a chronic disease. A system of coordinated healthcare interventions and communications for patients with conditions in which patient self-care efforts are significant in the management of their condition.

Drug

a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Due Diligence

a process employed by Manulife Financial to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the Plan Document. This process may use pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an advisory body.

Earnings

your regular rate of pay from your employer (prior to deductions), excluding regular bonuses, regular overtime pay and regular commissions. Earnings may include other income as agreed to in writing by your employer and Manulife Financial.

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be the lesser of:

- the amount reported on your claim form, or
- the amount reported by your employer to Manulife Financial and for which premiums have been paid.

Exclusive Distribution

Manulife Financial approved vendors.

Experimental or Investigational

not approved as an effective, appropriate and essential treatment of an illness or injury.

Immediate Family Member

you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

Explanation of Commonly Used Terms

Interchangeable Drug

includes but is not limited to:

- a generic equivalent to the brand name drug deemed to be interchangeable by law where the drug is dispensed;
- a drug that contains the same active ingredient that has not been deemed interchangeable in the province where the drug is dispensed; but has been identified as interchangeable by Manulife Financial.

Licensed, Certified, Registered

the status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority, in the place where the service is provided.

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative

if two or more drugs, supplies or services result in therapeutically similar results, or prescribing guidelines recommend alternate drugs, supplies or services be tried first that are lower in cost, the lower cost alternative will be considered.

Medically Necessary

accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of an illness or injury. Manulife Financial has the right after due diligence has been completed to determine whether the drug, service or supply is covered under the Plan Document.

Non-Evidence Limit

you must submit satisfactory medical evidence to Manulife Financial for Benefit Amounts greater than this amount.

Patient Assistance Program

a program that provides assistance to you or your dependents who are prescribed select drugs, supplies or services. Manufacturers and distributors may provide patient assistance programs that include financial support, along with education and training.

Pharmacoeconomics

the scientific discipline that evaluates the value of pharmaceutical drugs, clinical services or supplies. This discipline includes but is not limited to clinical evaluations, risk analysis, economic value and the cost consequences to plans. Pharmacoeconomic studies serve to guide optimal healthcare resource allocation, in a standardized and scientifically grounded manner as determined by Manulife Financial.

Prior Authorization

a claims management feature applied to a specific list of drugs, supplies or services to determine eligibility based on predefined clinical criteria and a pharmacoeconomic or cost effectiveness evaluation.

Explanation of Commonly Used Terms

Provincial Plan

any plan which provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.

Qualifying Period

a period of continuous total disability, starting with the first day of total disability, which you must complete in order to qualify for disability benefits.

Reasonable and Customary

the lowest of:

- the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife Financial,
- the amount shown in the applicable professional association fee guide, or
- the maximum price established by law.

Waiting Period

the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.

Ward

a hospital room with 3 or more beds which provides standard accommodation for patients.

Why Group Benefits?

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance.

But government plans provide only basic coverage. Medical expenses or a disability can create financial hardship for you and your family.

Private health care and disability programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Employer's Representative

Your employer is responsible for ensuring that all employees are covered for the Benefits to which they are entitled by reporting all new enrolments, terminations, changes, etc., and keeping all records up to date.

As a member of this Group Benefit Program, it is up to you to provide your employer with the necessary information to perform such duties.

Your Employer's representative is _____
Phone Number: _____

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Enrolment or Re-enrolment Application form, available from your employer. Your employer then forwards the application to Manulife Financial.

Making Changes

To ensure that coverage is kept up to date for yourself and your dependents, it is vital that you report any changes to your employer. Such changes could include:

- change in Dependent Coverage
- change in Beneficiary
- applying for coverage previously waived
- change in Name

Naming a Beneficiary

Manulife Financial does not accept beneficiary designations for any benefits other than Employee Life Insurance, Employee Optional Life Insurance and Accidental Death and Dismemberment.

This Plan contains a provision removing or restricting the right of the covered person to designate persons to whom or for whose benefit money is to be payable.

How to Submit a Claim

All claim forms, available from your employer, must be correctly completed, dated and signed. Remember, always provide your Group Policy Number, Plan Document Number and your Certificate number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim.

Your employer can assist you in properly completing the forms, and answer any questions you may have about the claims process and your Group Benefit Program.

You may not commence legal action against the Employer or the Administrator less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against the Employer or the Administrator for the recovery of money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or applicable legislation.

Payment of Extended Health Care and Dental Claims

Once the claim has been processed, Manulife Financial will send a Claim Statement to you.

The top portion of this form outlines the claim or claims made, the amount subtracted to satisfy deductibles, and the benefit percentage used to determine the final payment to be made to you. If you have any questions on the amount, your employer will help explain.

The bottom portion of this form is your claims payment, if applicable. Simply tear along the perforated line, endorse the back of the cheque and you can cash it at any chartered bank or trust company.

You should receive settlement of your claim within three weeks from the date of submission to Manulife Financial. If you have not received payment, please contact your employer.

Co-ordination of Extended Health Care and Dental Care Benefits

If you or your dependents are covered for similar benefits under another Plan, this information will be taken into account when determining the amount of expenses payable under this Program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of covered medical and dental expenses from all Plans, up to a total of 100% of the actual expense incurred.

Plan means:

- other Group Benefit Programs,
- any other arrangement of coverage for individuals in a group, and
- individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

The Claims Process

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the “Primary Carrier” (i.e., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the “Secondary Carrier” (i.e., responsible for making the payment to cover the remaining eligible expense).

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

- For Claims incurred by you or your Dependent Spouse:

The Plan covering you or your Dependent Spouse as an employee/member pays benefits before the Plan covering you or your Spouse as a dependent.

In situations where you or your Spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:

- The Plan where the person is covered as an active full-time employee, then
- The Plan where the person is covered as an active part-time employee, then
- The Plan where the person is covered as a retiree.

- For Claims incurred by your Dependent Child:

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

However, if you and your Spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then
- The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse’s Plan will pay benefits for the Dependent Child), then
- The Plan of the parent not having custody of the child, then
- The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse’s Plan will pay benefits for the Dependent Child).
- Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

The Claims Process

- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.
- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.
- If the person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.
- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.
- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits if you:

- are a part-time employee of PetSmart, Inc and work at least the Required Number of Hours,
- are a member of an eligible class,
- are younger than the Termination Age,
- are residing in Canada, and
- have completed the Waiting Period.

The Termination Age and Waiting Period may vary from benefit to benefit. For this information, please refer to each benefit in the section entitled Your Group Benefits.

Your dependents are eligible for coverage on the date you become eligible or the date you first acquire a dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

Required Number of Hours

For Part-time Employees - normal work schedule of at least 15 hours per week.

Medical Evidence

Medical evidence is required for all benefits, except Dental, when you make a Late Application for coverage on any person. Medical evidence is required when you apply for coverage in excess of the Non-Evidence Limit.

Late Application

An application is considered late when you:

- apply for coverage on any person after having been eligible for more than 31 days, or
- re-apply for coverage on any person whose coverage had earlier been cancelled.

If you apply for benefits that were previously waived because you were covered for similar benefits under your spouse's plan, your application is considered late when you:

- apply for benefits more than 31 days after the date benefits terminated under your spouse's plan, or
- apply for benefits, and benefits under your spouse's plan have not terminated.

Medical evidence can be submitted by completing the Evidence of Insurability form, available from your employer. Further medical evidence may be requested by Manulife Financial.

Late Dental Application

If you apply for coverage for Dental for yourself or your dependents late, the benefit will be limited to \$125 for each covered person for the first 12 months of coverage.

Effective Date of Coverage

- If medical evidence is not required, your Group Benefits will be effective on the date you are eligible.
- If medical evidence is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife Financial, whichever is later.

You must be actively at work for plan benefit coverage to become effective. If you are not actively at work on the date your coverage would normally become effective, your coverage will take effect on the next day on which you are again actively at work.

Your dependent's coverage becomes effective on the date the dependent becomes eligible, or the date any required medical evidence on the dependent is approved by Manulife Financial, whichever is later.

Your dependent's coverage will not be effective prior to the date your coverage becomes effective.

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

- the date you cease to be an eligible employee
- the date you cease to be actively at work, unless the Group Policy or the Plan Document allows for your coverage to be extended beyond this date
- the date your employer terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy or Plan Document terminates or coverage on the class to which you belong terminates
- the date you reach the Termination Age
- the date of your death

Your dependents' coverage terminates on the date your coverage terminates or the date the dependent ceases to be an eligible dependent, whichever is earlier.

Your Group Benefits

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0114822.

If you die while insured, this benefit provides financial assistance to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

The Benefit

Benefit Amount - 1 times your annual earnings, to a maximum of \$350,000 (minimum benefit amount of \$10,000)

Non-Evidence Limit - \$350,000

Qualifying Period for Waiver of Premium - 182 days

Termination Age - your benefit amount reduces by 50% at age 65 and terminates upon your retirement

Waiting Period

first of the month following 6 months for employees for employees hired on or prior to the Group Policy Effective Date

first of the month following 6 months for employees for all other employees

Naming a Beneficiary

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your Plan Administrator.

You should review your beneficiary designation to be sure that it reflects your current intent.

Submitting a Claim

To submit an Employee Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your Plan Administrator.

Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 12 months from the date of the loss.

To submit a claim for the Waiver of Premium benefit you must complete a Waiver of Premium claim form, which is available from your Plan Administrator. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 180 days from the end of the Qualifying Period.

Waiver of Premium

If you become Totally Disabled while insured and prior to age 65 and meet the Entitlement Criteria outlined below, your Life Insurance will continue without payment of premium.

Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience.

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled
- Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience.
- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial

At any time, Manulife Financial may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit
- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience.
- the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial
- the date you do not attend an examination by an examiner selected by Manulife Financial
- the date of your death
- the date of your 65th birthday

Your Group Benefits

Recurrent Disability

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived, and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, Manulife Financial will waive the Qualifying Period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months after cessation of your Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Employee Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Employee Life Insurance. If you die during this 31-day period, the amount of Employee Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0114822.

If you die while insured, this benefit provides financial assistance to your beneficiary, in addition to your Employee Life Insurance Benefit. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

The Benefit

Benefit Amount - increments of \$10,000, to a maximum of \$200,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability.

Qualifying Period for Waiver of Premium - 182 days

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

Waiting Period

first of the month following 6 months for employees hired on or prior to the Group Policy Effective Date

first of the month following 6 months for all other employees

To apply for Employee Optional Life Insurance you must complete the Application for Optional Life form which is available from your Plan Administrator.

For details on **Naming a Beneficiary**, **Submitting a Claim** and **Conversion Privilege**, please refer to Employee Life Insurance.

Waiver of Premium

If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium).

Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

Dependent Life Insurance

The Dependent Life Insurance Benefit is insured under Manulife Financial's Policy G0114822.

If one of your dependents dies while insured, the amount of this benefit is paid to you.

The Benefit

Benefit Amount - \$10,000 spouse; \$5,000 each dependent child

Termination Age - employee's age 70 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date

first of the month following 6 months for all other employees

Submitting a Claim

To submit a Dependent Life Insurance claim, you must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 12 months from the date of loss.

Waiver of Premium

If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium).

Conversion Privilege

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse's application for the individual policy, along with the first monthly premium, must be received by Manulife Financial, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for spousal coverage.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Your Group Benefits

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0114822.

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

The Benefit

Benefit Amount - 1 times your annual earnings, to a maximum of \$350,000 (minimum benefit amount of \$10,000)

Non-Evidence Limit - \$350,000

Qualifying Period for Waiver of Premium - 182 days

Termination Age - your benefit amount reduces by 50% at age 65 and terminates at age 70 or retirement, whichever is earlier.

Waiting Period

first of the month following 6 months for employees hired on or prior to the Group Policy Effective Date

first of the month following 6 months for all other employees

Schedule of Losses

A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury
- occurs within 365 days from the date of the accidental injury
- is total and irreversible or irrecoverable

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%

- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 66 2/3%
- Loss of Sight of One Eye - 66 2/3%
- Loss of Speech or Hearing in Both Ears - 66 2/3%
- Loss of Thumb and Index Finger One Hand - 33 1/3%
- Loss of at least Four Fingers of One Hand - 33 1/3%
- Loss of Hearing in One Ear - 25%
- Loss of All Toes of One Foot - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident.

No more than 100% will be paid for all losses due to any one accidental Injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while you are living).

Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

Naming a Beneficiary

See Employee Life Insurance... Naming a Beneficiary.

Submitting a Claim

To submit an Accidental Death Claim, your beneficiary must complete a Life Claim form.

To submit a Dismemberment Claim, you must complete an Accidental Dismemberment Claim form.

Both forms are available from your Plan Administrator, and require a physician's statement.

A completed claim form must be submitted within 12 months from the date of loss.

Waiver of Premium

If, while the Group Policy is in force, your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the benefit terminates.

Your Group Benefits

Exclusions

No Accidental Death & Dismemberment benefits are payable if the loss results from:

- suicide or self-inflicted injuries
- war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion
- an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

Extended Health Care

Your Extended Health Care Benefit is provided directly by PetSmart, Inc. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

If you or your dependents incur charges for any of the Covered Expenses specified, your Extended Health Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

Drug Benefit and Pharmacy Services for Quebec Residents

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain requirements under Quebec's prescription drug insurance and pharmacy services insurance legislation (An Act Respecting Prescription Drug Insurance and the Health Insurance Act And Amending Various Legislative Provisions). If you and your dependents reside in Quebec, the provisions specified under Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec, will apply to your drug benefit.

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Dispensing Fee Maximum - \$12.00 per prescription

Benefit Percentage (Co-insurance)

100% for
Hospital Care
Vision Care

90% for
Drugs

80% for
Professional Services
Medical Supplies and Services

Note:

The Benefit Percentage for Out-of-Province/Out-of-Canada Emergency Medical Treatment is 100%.

The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.

The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - employee's retirement

Waiting Period

first of the month following 6 months for employees hired on or prior to the Plan Document Effective Date

first of the month following 6 months for all other employees

Covered Expenses

The expenses specified are covered to the extent that they are reasonable and customary, as determined by Manulife Financial or your employer, provided they are:

- medically necessary for the treatment of an illness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable
- used as prescribed or recommended by a physician
- associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the plan as of the date of approval as determined by the administrator and shared with your employer as required.

In the event that a provincial plan or government-sponsored program or plan or legally mandated program excludes, discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

Your Group Benefits

This plan will not automatically assume eligibility for all drugs, services and supplies. New drugs, existing drugs with new indications, services and supplies are reviewed by Manulife Financial using the due diligence process. Once this process has been completed, the decision will be made by Manulife Financial to include as a covered expense, include with prior authorization criteria, exclude or apply maximum limits.

Manulife Financial maintains a list of drugs, services and supplies that require prior authorization. Prior authorization is applied to ensure that the therapy prescribed is medically necessary. Where there are lower cost alternative treatments or prescribing guidelines recommend alternative drugs be tried first that are lower in cost, you or your eligible dependents will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

At Manulife Financial's discretion, medical information, test results or other documentation will be required from your physician to determine the eligibility of the drug, service or supply.

Manulife Financial has the right to ensure you or your dependents access Manulife Financial's exclusive distribution channels where applicable when purchasing a drug, service or supply. Manulife Financial may decline a drug, service or supply purchased from a provider outside the exclusive distribution channel.

Adherence

Non-compliance may result in the drug, service or supply no longer being eligible for reimbursement.

Patient Assistance Programs

Manulife Financial may require you or your dependents to apply to and participate in any patient assistance program to which you or your dependents are entitled. Manulife Financial reserves the right to reduce the amount of a covered expense by the amount of financial assistance you or your dependents are entitled to receive under a patient assistance program.

Disease Management Programs

Participation in a disease management program may be required. Participation will be at the discretion of Manulife Financial.

Advance Supply Limitation

Payment of any Covered Expenses under this benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time.

The maximum quantity of drugs that will be payable for each prescription will be limited to the lesser of:

- a) the quantity prescribed by your physician or dentist, or
- b) a 34 day supply.

A quantity of up to a 100 day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by your physician and pharmacist.

Hospital Care

- charges, in excess of the hospital's public ward charge, for semi-private accommodation, provided:
 - the person was confined to hospital on an in-patient basis, and
 - the accommodation was specifically elected in writing by the patient
- charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered

ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

- drugs which by law or convention require a written prescription of a physician or dentist
- oral contraceptives
- injectable medications
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- non-prescription drugs and supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment)
- fertility drugs

Charges for the following expenses are not covered:

- the administration of serums, vaccines, or injectable drugs
- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence
- anti-smoking drugs
- anti-obesity drugs
- drugs used in the treatment of a sexual dysfunction

- Drug Maximums

Fertility drugs - \$10,000 per lifetime

Preventive vaccines and medicines (oral or injected) - \$1,000 per calendar year

All other covered drug expenses - Unlimited

Your Group Benefits

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

Manulife Financial can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product, the maximum amount covered is the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

Reimbursement at the cost of a prescribed drug, where a lower cost alternative drug is available, will only be considered if medical evidence is provided by the treating physician to support why the lower cost alternative drug cannot be tolerated or is ineffective.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

- a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Vision Care

- eye exams, to a maximum of 1 exam per calendar year
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of \$250 per 12 months for persons under age 18 and \$250 per 24 months for persons age 18 and over
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be \$200 per 12 months for persons under age 18 and \$200 per 24 months for persons age 18 and over
- visual training, \$200 per lifetime per person

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- Osteopath: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- Podiatrist/Chiropracist: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- Massage Therapist: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- Naturopath: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- Speech Therapist: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- Physiotherapist: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- Mental Health Practitioners*: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist
- Acupuncturist: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropracist, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist

Your Group Benefits

- Athletic Therapist: \$1,000 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropract, massage therapist, naturopath, speech therapist, physiotherapist, mental health practitioners, acupuncturist and athletic therapist

*Mental Health Practitioners include Clinical Counsellors, Marriage and Family Therapists, Psychoanalysts, Psychologists, Psychotherapists and Social Workers only

Expenses for some of these Professional Services may be payable in part by Provincial Plans. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Recommendation by a physician for Professional Services is not required.

Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

- Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

- a registered nurse, or
- a registered nursing assistant (or equivalent designation) who has completed an approved medications training program

Covered Expenses are subject to a maximum of \$10,000 per calendar year.

Charges for the following services are not covered:

- service provided primarily for custodial care, homemaking duties, or supervision
- service performed by a nursing practitioner who is an immediate family member or who lives with the patient
- service performed while the patient is confined in a hospital, nursing home, or similar institution
- service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household

Pre-Determination of Benefits

Before the services begin, it is advisable that you submit a detailed treatment plan with cost estimates. You will then be advised of any benefit that will be provided.

Ambulance

- licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available

Medical Equipment

- rental or, when approved by Manulife Financial or your employer, purchase of:
 - Mobility Equipment: crutches, canes, walkers, and wheelchairs

- Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses
- surgical stockings, to a maximum of 4 pairs per calendar year
- surgical brassieres, to a maximum of 4 per calendar year
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes and modifications and adjustments to stock-item orthopaedic shoes or regular footwear, to a maximum of \$150 per calendar year (recommendation of either a physician or a podiatrist/chiropractist is required)
- custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, up to a maximum of \$150 per calendar year (must be constructed by a certified orthopaedic footwear specialist)
- casted, custom-made orthotics, to a maximum of \$500 per 3 calendar years (recommendation of either a physician or a podiatrist/chiropractist is required)
- cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of \$500 per 5 calendar years

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of \$250 per lifetime
- oxygen
- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec
- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing

Fertility Treatment

The cost of eligible non-drug fertility expenses based on the list from the Canada Revenue Agency (CRA) Medical Expense Tax Credit (METC), up to a maximum of \$15,000 per person, per lifetime.

Gender Affirmation Treatment

Charges for feminization procedures as follows:

- breast/chest surgery - augmentation mammoplasty (implants/lipofilling)

Your Group Benefits

- genital surgery - penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty, scrotoectomy, labiaplasty
- non-genital, non-breast interventions - facial feminization surgery such as rhinoplasty, and blepharoplasty, abdominoplasty, liposuction, lipofilling, gluteal augmentation (implants/lipofilling), hair reconstruction, electrolysis or laser hair removal of facial, body hair or skin graft, reduction thyroid chondroplasty and laryngoplasty/vocal cord surgery

Charges for masculinization procedures as follows:

- breast/chest surgery - mastectomy, chest masculinization
- genital surgery - hysterectomy, salpingo-oophorectomy, metoidioplasty or phalloplasty, urethroplasty, vaginectomy, glansplasty, scrotoplasty and insertion of testicular implants; and insertion of an erectile device
- non-genital, non-breast interventions – facial masculinization surgery such as facial bone reconstruction, rhinoplasty and blepharoplasty, abdominoplasty, liposuction, lipofilling, pectoral implants, electrolysis or laser hair removal of skin graft and laryngoplasty/vocal cord surgery

Charges for the following expenses are not covered:

- expenses related to travel or accommodation under this benefit
- services obtained outside of Canada
- services that are considered cosmetic, except as otherwise provided under the list of eligible expenses as outlined in the feminization and masculinization procedures mentioned above
- expenses related to the reversal of gender affirmation treatments
- expenses related to sperm preservation and/or cryopreservation of fertilized embryos and expenses related to infertility
- any services/expenses payable under any Provincial/Territorial Plan.

The purpose of this coverage is related to masculinization or feminization, not elective cosmetic enhancement. All eligible services must be medically necessary and ordered by a physician involved in the transitioning treatment.

In order to be eligible for the gender affirmation treatment expenses outlined in this section, the covered person must go through the provincial/territorial process, where provincial/territorial coverage exists.

A covered person must provide the Administrator with one of the following:

- proof of approval from the province/territory that has accepted coverage under their gender affirmation program, where provincial/territorial coverage exists, OR
- proof of completing a recognized program at a specialized gender identity treatment centre (such as the CAMH Gender Identity Clinic), OR
- proof that the covered person has met the clinical eligibility for gender affirming surgery as determined by the World Professional Association for Transgender Health (WPATH) Standards of Care (SoC) criteria and have been assessed by a physician, specialist, nurse practitioner (NP) and/or a health care professional (HCP) trained in the WPATH SoC.

If the covered person elects not to follow the WPATH identity treatment guidelines or not to go through the provincial/territorial process (where provincial/territorial coverage exists), the covered person will not be eligible for any of the gender affirmation treatment expenses outlined in this section.

Only expenses incurred while the covered person is covered/insured under this plan and while this benefit provision is in force will be eligible for consideration.

Manulife is responsible for determining a covered person's eligibility for coverage under the gender affirmation benefit. Before incurring an expense, the covered person must contact the Administrator to predetermine the eligibility of their claim. The Administrator reserves the right to request details of the services, along with provincial/territorial approval with respect to the assessment/approval for coverage under the provincial/territorial gender affirmation program. The Administrator will assess all medical expenses based on the terms of this plan and considering WPATH's standards of care for Gender Identity Dysphoria.

Covered Expenses are subject to a maximum of \$10,000 per lifetime.

Out-of-Province/Out-of-Canada

- treatment required as a result of a medical emergency which occurs while temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence, up to a maximum of \$5,000,000 per lifetime.

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of his province of residence, or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

Stable means that, in the 90 days before departure, the covered person (you or your dependent) has not:

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

Coverage is not available if you (or your dependents) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

Coverage is also available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to his home province or territory.

- referral outside Canada for treatment which is available in Canada to a maximum of \$3,000 per 3 calendar years

Your Group Benefits

If, while outside Canada on referral for medical treatment, the covered person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the maximum of \$3,000 every 3 calendar year(s).

For all non-emergency medical treatment out of Canada:

- the treatment must be recommended by a physician practicing in Canada, and
- it is advisable that you submit a detailed treatment plan with cost estimates before treatment begins. You will then be notified of any benefit that will be provided.

Charges for the following are payable under this expense:

- physician's services
- hospital room and board at standard ward rates. Charges in excess of ward rates are payable, if hospital coverage is provided under this Benefit Program.
- the cost of special hospital services
- hospital charges for out-patient treatment
- licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available
- medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides

The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the Provincial Plan.

Charges incurred outside the province of residence for all other Covered Extended Health Care Expenses are payable on the same basis as if they were incurred in the province of residence.

Emergency Travel Assistance

Emergency Travel Assistance provides travel assistance for you and your dependents while you are temporarily outside your province of residence. The assistance services are delivered through an international organization, specializing in travel assistance.

Assistance is provided for both Medical and Non-Medical travel emergencies. Services are available during the period that you are covered for Out-of-Province/Out-of-Canada emergency medical treatment, provided under this benefit.

In addition, Emergency Travel Assistance also provides you and your dependents with Health Advice and Assistance, whenever and wherever such services are needed - whether at home or while travelling.

Details on your Emergency Travel Assistance benefit are provided below, as well as in your Emergency Travel Assistance brochure.

Medical Emergency Assistance

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of his province of residence, or

- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

Stable means that, in the 90 days before departure, the covered person (you or your dependent) has not:

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

Coverage is not available if you (or your dependents) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

Coverage is also available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to his home province or territory.

a) **24-Hour Access**

Multilingual assistance is available 24 hours a day, seven days a week, through telephone (toll-free or call collect), telex or fax.

b) **Medical Referral**

Referral to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of coverage, is provided.

c) **Claims Payment Service**

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed \$200 (Canadian), payment of such expenses will be arranged and claims co-ordinated on behalf of the covered person.

Payment and co-ordination of expenses will take into account the coverage that the covered person is eligible for under a Provincial Plan and this benefit. If such payments are subsequently determined to be in excess of the amount of benefits to which the covered person is entitled, the administrator shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from you.

d) **Medical Care Monitoring**

Medical care and services rendered to the covered person will be monitored by medical staff who will maintain contact, as frequently as necessary, with the covered person, the attending physician, the covered person's personal physician and family.

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Out-of-Province or Out-of-Canada.

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If medically necessary for a qualified medical attendant to accompany the covered person, expenses incurred for round-trip transportation will be paid.

f) **Return of Dependent Children**

If dependent children are left unattended due to the hospitalization of a covered person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

If necessary for a qualified escort to accompany the dependent children, expenses incurred for round-trip transportation will be paid.

g) **Trip Interruption/Delay**

If a trip is interrupted or delayed due to an illness or injury of a covered person, one-way economy transportation will be arranged to enable each covered person and a Travelling Companion (if applicable) to rejoin the trip or return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

A Travelling Companion is any one person travelling with the covered person, and whose fare for transportation and accommodation was pre-paid at the same time as the covered person's fare.

If the covered person chooses to rejoin the trip, further expenses incurred which are related directly or indirectly to the same illness or injury, will not be paid.

If a covered person must return home due to the hospitalization or death of an immediate family member, one-way economy transportation will be arranged and expenses incurred, over and above any allowance available under pre-paid travel arrangements, will be paid.

h) **After Hospital Convalescence**

If a covered person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the maximum shown in part l) of this provision.

i) **Visit of Family Member**

Expenses incurred for round-trip economy transportation will be paid for an immediate family member to visit a covered person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance by the administrator.

j) **Vehicle Return**

If a covered person is unable to operate his owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the covered person's home or nearest appropriate rental agency will be paid, up to a maximum of \$1,000 (Canadian).

k) **Identification of Deceased**

If a covered person dies while travelling alone, expenses incurred for round-trip economy transportation will be paid for an immediate family member to travel, if necessary, to identify the deceased prior to release of the body.

l) **Meals and Accommodation**

Under the circumstances described in parts f),g),h),i), and k) of this provision, expenses incurred for meals and accommodation will be paid, subject to a combined maximum of \$2,000 (Canadian) per medical emergency.

Non-Medical Assistance

a) **Return of Deceased to Province of Residence**

In the event of the death of a covered person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. Expenses incurred for the preparation and transportation of the body will be paid, up to a maximum of \$5,000 (Canadian). Expenses related to the burial, such as a casket or an urn, will not be paid.

b) **Lost Document and Ticket Replacement**

Assistance in contacting the local authorities is provided, to help a covered person in replacing lost or stolen passports, visas, tickets or other travel documents.

c) **Legal Referral**

Referral to a local legal advisor, and if necessary, arrangement for cash advances from the covered person's credit cards, family or friends, is provided.

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

Telephone message service is provided for messages to or from family, friends or business associates. Messages will be held for up to 15 days.

f) **Pre-trip Assistance Service**

Up-to-date information is provided on passport and visa, vaccination and inoculation requirements for the country where the covered person plans to travel.

Health Advice and Assistance

The following services are available for a covered person when required as a result of an illness or injury:

a) **After Hours Access to a Registered Nurse**

Toll free telephone access to a registered nurse is available seven days a week, during the hours that a family physician is not readily accessible.

b) **Medical Advice**

Medical advice will be provided on:

- i) whether the illness or injury can be safely treated at home or will require a visit to a physician or hospital emergency room,
- ii) the type of side effect to expect from a prescribed drug, and
- iii) other health related services that may be requested or required by the covered person.

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c) **Link to 911**

If necessary, a covered person will be immediately linked to their local 911 emergency service for medical assistance.

d) **Follow-Up Call**

Where appropriate, to monitor the care of the covered person, the registered nurse will follow-up with the covered person within 24 hours after the medical advice is provided.

Exceptions

The administrator, and the company contracted by the administrator to provide the travel assistance services described in this benefit, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of a covered person to obtain medical treatment or emergency assistance services for any reason.

Emergency assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances which interfere with or prevent the provision of any services.

How to Access Emergency Travel Assistance - Your Emergency Travel Assistance Card

Your Emergency Travel Assistance card lists the toll free numbers to call in case of an emergency, while travelling outside your province. The toll free number will put you in touch with the international travel assistance organization.

Your Emergency Travel Assistance card also lists your I.D. number and plan document number, which the travel assistance organization needs to confirm that you are covered by Emergency Travel Assistance.

If you do not have an Emergency Travel Assistance Card, please contact your employer.

Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from your employer.

All applicable receipts must be attached to the completed claim form when submitting it to Manulife Financial.

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your coverage, all claims must be submitted no later than 90 days from the termination date.

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to Manulife Financial, along with the explanation of payment from the Provincial Plan.

Subrogation (Third Party Liability)

If your medical expenses result from an injury caused by another person and you have the legal right to recover damages, your employer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse your employer those amounts you recover which, when added to the payments you received from your employer, exceed 100% of your incurred expenses.

Exclusions

No Extended Health Care benefits are payable for expenses related to:

- for Out-of-Province/Out-of-Canada and Emergency Travel Assistance only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

Your Group Benefits

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

If you and your dependents reside in Quebec, the following provisions apply to your drug benefit coverage.

Covered Expenses

The following expenses are covered:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred, and
- covered pharmacy services that are to be paid when the drug is on the RAMQ List, and
- drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

Coverage for drugs on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List) and pharmacy services published for private plans

The following provisions apply to the coverage of drugs that are on the RAMQ List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act (R.S.Q. c., A-29-01). Coverage for all other drugs will be subject to the regular provisions included in this Benefit Booklet:

a) Benefit Percentage

Prior to the annual out-of-pocket maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

- i) For any drug on the RAMQ List which is not otherwise covered under the terms of this Benefit, the percentage payable is the percentage as set out by the then applicable Legislation
- ii) for any Legislated pharmacy services which are not otherwise covered under the terms of this Benefit, the percentage payable is as set out by the then applicable Legislation
- iii) For any drug on the RAMQ List which is covered under the terms of this Benefit, the percentage payable is the greater of:
 - the benefit percentage stated under The Benefit, and
 - the percentage as set out by the then applicable Legislation.

After the annual out-of-pocket maximum has been reached, the percentage of covered drug expenses payable under this benefit will be 100%.

b) Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is a portion of covered drug expenses or covered pharmacy services which must be paid by you and your spouse in a calendar year, before the percentage payable under this benefit will be 100%.

Amounts that will be applied to the annual out-of-pocket maximum are

- i) deductible amounts, and

- ii) the portion of covered drug expenses that is paid by a covered person, when the percentage of covered expenses payable under this benefit is less than 100%, and
- iii) covered pharmacy services that are performed by pharmacists for drugs on the RAMQ formulary.

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for your dependent children.

For the purposes of calculating the out-of-pocket maximum for you and your spouse, those portions of covered drug expenses and covered pharmacy services paid for your dependent children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

c) Deductible

Deductible amounts (if any) for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the deductible will not apply.

d) Lifetime Maximums

Lifetime maximums (if any) will not apply to drugs on the RAMQ List or covered pharmacy services. Drug and covered pharmacy service coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered, and
- ii) only covered pharmacy services that are performed for drugs on the RAMQ List are covered, and
- iii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

e) Eligible Dependent Children

Your eligible dependent children who are in full-time attendance at an accredited educational institution will be covered until the later of:

- i) the age specified in this Benefit Booklet (please refer to definition of child in the Explanation of Common Insurance Terms), and
- ii) age 26.

Drug coverage and covered pharmacy services provided for dependent children after the age stated in this Benefit Booklet is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered, and
- ii) only covered pharmacy services performed for a drug in the RAMQ List are covered, and
- iii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

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f) Termination Age for Covered Drug and Pharmacy Service Expenses

Provided you are otherwise eligible for the drug benefit, the Termination Age (if any) for the drug benefit will not apply. Drug coverage provided after the Termination Age specified under the benefit is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered,
- ii) only covered pharmacy services related to a drug on the RAMQ List are covered,
- iii) the percentage payable by the Administrator for covered expenses is the percentage as stipulated in the then applicable Legislation,
- iv) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation, and
- v) the cost required for the drug coverage is the cost of the Extended Health Care benefit.

Coverage for drugs that are listed as a covered expense in this Benefit Booklet but are not on the RAMQ List

Coverage for drugs that are listed as a covered expense under this Benefit but not on the RAMQ List will be subject to all the standard provisions included in this Benefit Booklet.

Dental Care

Your Dental Care Benefit is provided directly by PetSmart, Inc. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

If you or your dependents require any of the dental services specified under Covered Expenses, your Dental Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Deductible - Nil

Dental Fee Guide - Current Fee Guide for General Practitioners for your province of residence

Benefit Percentage (Co-insurance)

90% for Basic Services - Level I

80% for Supplementary Basic Services - Level II

50% for Dentures - Level III

50% for Major Restorative Services - Level IV

50% for Orthodontics - Level V

Benefit Maximums

\$2,500 per calendar year combined for Level I, Level II, Level III and Level IV

\$2,000 per lifetime for Level V

Termination Age - employee's retirement

Waiting Period

first of the month following 6 months for employees hired on or prior to the Plan Document Effective Date

first of the month following 6 months for all other employees

Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of a covered person while covered under this benefit
- are incurred for services provided by a dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license
- are reasonable as determined by your employer or Manulife Financial, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by your employer or Manulife Financial, if the expenses are not listed in the Dental Fee Guide

Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, your employer will pay benefits as if the least expensive course of treatment were used. Your administrator will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Level I - Basic Services

- complete oral exam, once per 2 calendar years
- full-mouth x-rays, once per 2 calendar years
- one unit of light scaling and one unit of polishing, once every 6 months, when the service is performed outside Quebec, or prophylaxis (polishing), once every 6 months, when the service is performed in Quebec
- recall exams, bitewing x-rays, and fluoride treatments, once every 6 months
- routine diagnostic and laboratory procedures
- initial oral hygiene instruction, plus one recall
- fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:
 - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or

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- the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- pre-fabricated full coverage restorations (metal and plastic)
- space maintainers (appliances placed for orthodontic purposes are not covered)
- minor surgical procedures and post surgical care
- extractions (including impacted and residual roots)
- consultations, anaesthesia, and conscious sedation
- denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery

Level II - Supplementary Basic Services

- surgical procedures not included in Level I (excluding implant surgery)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
 - scaling not covered under Level I, and root planing, up to a combined maximum of 16 units per calendar year
 - provisional splinting
 - occlusal equilibration, up to a maximum of 8 units per calendar year
- endodontic services which include root canals and therapy, root amputation, apexifications and periapical services
 - root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime
 - re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment

Level III - Dentures

- initial provision of full or partial removable dentures
- replacement of removable dentures, provided the dentures are required because:
 - a natural tooth is extracted and the existing appliance cannot be made serviceable
 - the existing appliance is at least 60 months old and cannot be made serviceable, or
 - the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation
- expenses for dentures required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Level IV - Major Restorative Services

- crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay
- inlays, covering at least 3 surfaces, provided the tooth cusp is missing
- initial provision of fixed bridgework
- implants, or any services rendered in conjunction with implants
- replacement of bridgework, provided the new bridgework is required because:
 - a natural tooth is extracted and the existing appliance cannot be made serviceable
 - the existing appliance is at least 60 months old and cannot be made serviceable, or
 - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation
- expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Level V - Orthodontics

- orthodontic services

Late Entrant Limitation

If you or your dependents become covered for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to \$125 for each covered person.

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed \$500, it is suggested that you submit a detailed treatment plan, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Work in Progress When Coverage Terminates

Covered expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Plan Document or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Submitting a Claim

To submit a claim, you and your dentist must complete a Dental Claim form available from your employer.

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your coverage, all claims must be submitted no later than 90 days from the termination date.

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Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, your employer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse your employer those amounts you recover which, when added to the payments you received from your employer, exceed 100% of your incurred expenses.

Exclusions

No Dental Care benefits will be payable for expenses resulting from:

- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- anti-snoring or sleep apnea devices
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction
- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- services or supplies which are not specified as a covered expense under this benefit

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer will continue the Dependent Life, Extended Health Care and Dental Care benefits without requiring any contribution from you, until the earliest of:

- the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Commonly Used Terms)
- the date similar coverage is obtained elsewhere
- the date which is 2 years from your death, or
- the date the Plan Document terminates

